

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005015	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/13/2013
NAME OF PROVIDER OR SUPPLIER FRANCISCAN ST ANTHONY HEALTH - MICHIGAN CIT		STREET ADDRESS, CITY, STATE, ZIP CODE 301 W HOMER ST MICHIGAN CITY, IN 46360		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit is for a State hospital complaint investigation.</p> <p>Complaint: #IN00115727 Unsubstantiated -lack of sufficient evidence.</p> <p>Survey Date: 08/13/13</p> <p>Facility: # 005015</p> <p>Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor</p> <p>Franciscan St Anthony Health-Michigan City is in compliance with 410 IAC 15-1.5-5, Medical staff and 410 IAC 15-1.5-6, Nursing service, Hospital Licensure Rules.</p> <p>QA: cloughlin 08/20/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE